STATE OF WEST VIRGINIA

HEALTH CARE AUTHORITY

CERTIFICATE OF NEED PROGRAM

GENERAL

APPLICATION

FOR

CERTIFICATE OF NEED REVIEW

(Revised 02-01-02)

CASE FILE NUMBER: _____
(Assigned upon receipt of letter of intent)

GENERAL INFORMATION

1. This application is a general purpose form. Not all items relate to a specific project. If you have any questions about the Certificate of Need process or the applicability of any item on your project, feel free to contact the Certificate of Need Program staff.

2. A letter of intent must be submitted at least fifteen (15) days prior to the application. The letter of intent must include enough information to indicate the name of the project, its approximate location, nature, scope, cost and the time frame for the development of the service.

3. The Certificate of Need staff will review the application for completeness upon its receipt. Within fifteen (15) days, the application will either be declared complete or a request for additional information will be issued.

4. Any amendment to the application must be made in writing. If amendment is deemed to be substantial by the Certificate of Need Program, the review of the application may be extended or the application may be withdrawn and made subject to a new review cycle.

5. An applicant may withdraw its application at any time without prejudice. Applicants must notify the Certificate of Need Program in writing of such action.

6. Assemble the application in the same sequence as this form. In the upper right hand corner of each page, including attachments, specify the page number. In the upper left hand corner of each page, repeat the facility name and case file number. Response to items on the colored pages should be provided on white paper, repeating each question before providing your response. Those parts of the application printed on white paper should be completed and inserted following the item to which it is referenced.

7. Applicants must provide a signed original as well as three (3) copies of the entire application to:

   Director, Certificate of Need Program
   West Virginia Health Care Authority
   100 Dee Drive
   Charleston, West Virginia 25311-1692

   These copies should be submitted in the following manner:

   a. The original application must be in a three-ring, hard-back notebook with alphabetized section dividers.

   b. Three (3) copies are to be submitted unbound and unstapled.

8. Applicants must also provide one (1) copy of the entire application to:

Offices of the Insurance Commissioner
Consumer Advocacy Division
Post Office Box 50540
Charleston, West Virginia 25305-0540

9. The application and any other material in the case file become public documents and are available for inspection and copying upon request.

10. Data, State Health Plan Standards, and approved need methodologies will be provided by the Authority upon request only.

11. Certificate of Need law and regulations may be obtained by contacting:

Administrative Law Division
Secretary of State's Office
Building 1, Suite 157-K
Charleston, West Virginia 25305
(304)-558-6000

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SECTION A: IDENTIFICATION OF THE APPLICANT

Note: The applicant is the governing body or person proposing a new institution health service and who is, or will be, the licensee of the health care facility in which the service will be located. In those cases not involving a licensed health care facility, the governing body or person proposing to provide the service is the applicant. Incorporators or promoters who will not constitute the governing body or person responsible for the new service may not be the applicant.

1. _____
Name of Facility at Which Project Will Be Developed

_____
Project Name

_____
Address

_____
City County State Zip Code

Medicare Provider Number: _____

Medicaid Provider Number: _____

Type of License (attach copy): _____

2. _____
Name of Applicant

_____
Address of Applicant

_____
City County State Zip Code

_____
Name and Title of Chief Executive Officer Telephone

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3. Person to contact regarding this application

_____
Name and Title

_____
Organization

_____
Street

_____
City State Zip Code

_____
Telephone

4. Type of Project _____

5. Check the appropriate category, which describes the applicant.

PROPRIETARY	NON-PROFIT	GOVERNMENTAL
_____ Individual	_____ Corporation	_____ State
_____ Partnership	_____ Church	_____ County
_____ General	_____ Other (Specify)	_____ Other (Specify)
_____ Limited	_____	_____
_____ Corporation		
_____ Other (Specify)		

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6. Attach certificate of incorporation and filed articles of incorporation or certificate of limited partnership. If out of state corporation, attach a copy of the West Virginia Certificate of Authority. If already submitted with another application, cite name and case file number of project.

7. List the current membership of the Board of Directors and principal officers of the corporation. If partnership, provide the names of all general partners.

8. If an existing facility, list the owner(s) of record if other than the applicant.

SECTION B: AUTHORIZATION TO PURSUE PROJECT

1. Attach a copy of the resolution or minutes of the governing body meeting(s) or certified abstracts wherein this project and any related capital expenditures were approved.

2. Attach written authorization of the governing body empowering the signer of the application, the contact person(s) listed in Section A and any other individuals to act on behalf of the applicant during the course of this review.

SECTION C: DESCRIPTION OF PROJECT

1. Generally describe the project. The description should include:

   - objectives of the project
   - components of the project
   - capital expenditures associated with the project

2. If the facility or service is/will be managed or operated by someone other than the owner, specify and explain the relationship. Attach a copy of the contract or proposed contract under which the facility or service will be managed or operated.

3. Complete this table regardless of the effect the project has on the facility's bed capacity.

BED CLASSIFICATIONS	LICENSED BEDS	CON APPROVED	TOTAL CURRENT	PROPOSED PROJECT CHANGES		TOTAL PROPOSED BEDS
				INCREASE	DECREASE	
Gen. Med/surg. (adult)						
Gen. Med/surg. (pediatric)						
Psychiatric						
Obstetrics						
Orthopedic						
Chemical Detox.						
Other acute (specify)						
Swing Beds						
Medical/surgical intensive care						
Cardiac intensive care						
Pediatric intensive care						
Neonatal intensive care						
Burn care						
Psychiatric intensive care						
Other special care						
Other intensive care (specify)						
Total acute care						

CON File # _____

BED CLASSIFICATIONS	LICENSED BEDS	CON APPROVED	TOTAL CURRENT	PROPOSED PROJECT CHANGES		TOTAL PROPOSED BEDS
				INCREASE	DECREASE	
Skilled nursing long-term care						
Intermediate long-term care						
Psychiatric long-term care						
Mental retardation						
Personal care						
Respite						
Rehabilitation						
Chronic disease						
Chemical dependency						
Other (specify)						
Total non-acute						
TOTAL FACILITY						

4. Complete the following table for each ancillary service affected by the project. Complete for most recently completed fiscal and first full year of operation after completion of the project. Use separate lines for inpatient and outpatient components of the same service. Define service units used and state all assumptions used on a separate sheet of paper and attach.

SERVICE	CURRENT YEAR ENDING _____		PROJECTED YEAR ENDING_____	
	CAPACITY	UTILIZATION	CAPACITY	UTILIZATION

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5. Movable Equipment Cost

Provide a listing of movable equipment associated with project. Major items of equipment valued under $100,000 may be grouped by department or services. In the case of rooms, units, etc., list what common items each will contain. For donated equipment, list appraised value.

a. Equipment To Be Acquired by Purchase or Donation:

EQUIPMENT DESCRIPTION	COST	INSTALLATION RENOVATION	FAIR MARKET VALUE	TOTAL COST
TOTAL				

b. Equipment To Be Acquired by Lease:

EQUIPMENT DESCRIPTION	COST	INSTALLATION RENOVATION	FAIR MARKET VALUE	TOTAL COST
TOTAL				

* Specify terms of maintenance agreement if included in lease payment.

** Complete if the only capital expenditure associated with proposal is for the acquisition of equipment.

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6. For construction projects, complete the following for each site under construction.

   a. Description.

   b. Location described in writing and shown on a map.

   c. Acreage.

   d. Purchase cost or documented appraised value. Attach a copy of appraisal report.

   e. Estimated site development cost.

   f. Documentation of availability.

   g. Health Facility Licensure and Certification Section survey form, if proposed facility is subject to licensure.

7. Provide one full-size set of schematic (single-line) drawings, to scale, of the project which shows the relationships of the various departments or services to each other and the room arrangement in each department. Note the name of each room. Include reduced, but readable, copies in your application.

8. Provide a tabulation of square footage for each affected department of the facility and any proposed changes using the following format:

(A) SERVICE/ DEPT.	(B) EXISTING	PROPOSED PROJECT			TOTAL PROJECT (C-D-E)	TOTAL DEPT/ SERVICE WITH PROJECT	COST
		(C) NEW	(D) RENOVATED	(E) DELETED			
TOTAL FACILITY							

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9. Capital Cost of Project

Complete if any of the capital expenditure associated with the project is for land or buildings as well as equipment.

Note: Complete only those sub-items which apply to your project.

Costs should be based on timetable provided in Section D of this application. Review of cost increased, if necessary, will be based on delays in that timetable or rates of inflation that exceed the assumptions used to calculate costs.

a. Site Acquisition Costs:

		Subtotal
1. Purchase Price	_____	_____
2. Closing Costs	_____	_____
3. Other (specify)	_____	_____
Subtotal (a)		_____

b. Site Preparation Costs:

1. Demolition	_____
2. Earthwork	_____
3. Site Utilities	_____
4. Road, Parking and Walks	_____
5. Other (specify)	_____
a.	
b.	
c.	
Subtotal (b)	_____

c. Architectural and Engineering: Subtotal

1. Architectural Fees _____

2. Engineering Fess _____

Subtotal (c) _____

a. Other Consultant Fees:
(List each separately)

1. CON Preparation And Review Fees _____

2. Legal Fees* _____

3. _____ _____

Subtotal (d) _____

* If no specific amount agreed to, state the rate per hour and estimated number of hours.

b. Direct Construction Costs:

1. Cost of Materials _____

2. Cost of Labor _____

3. Fixed Equipment Included in Construction Contract _____

4. Contingency (___%) _____

Subtotal (e) _____

c. Moveable Equipment Costs:

(From Question 5 of Section E, page 7) _____

Subtotal (f) _____

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g. For all types of financing, complete the applicable items:

1. Legal Fees: Subtotal

a. Bond Counsel* _____

b. Underwriter's Counsel* _____

c. Applicant's Counsel * _____

d. Other* _____

* If no specific amount agreed to, state percentage or rate per hour and estimated number of hours.

2. Capitalized Interest (Interested earned less interest paid during construction.) _____

3. Feasibility Study _____

4. Other (Specify):

a. _____ _____

b. _____ _____

Subtotal (g) _____

TOTAL PROJECT COST _____

Anticipated construction start and end dates on which cost estimates are based:

_____ and _____

Estimated annual inflation rate used to project costs:

_____

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SECTION D: PROJECT TIMETABLE

Provide a timetable for incurring the obligation for any capital expenditure associated with the project and for implementation of the project.

SIGNIFICANT PHASES OF PROJECT	ESTIMATED MONTHS SUBSEQUENT TO CON APPROVAL
a. Land (site) acquired	
b. Final plans and specifications submitted to the HFED	
c. Financing arrangements completed	
d. Initial capital expenditure obligated	
e. Construction contract secured and signed	
f. Construction started	
g. Remaining capital expenditure obligated	
h. Equipment orders submitted	
i. Construction completed	
j. Request for substantial compliance review submitted to CON Program	
k. Project completed and in operation	

SECTION E: THE NEED AND ACCESSIBLITY OF THE POPULATION TO BE SERVIED

1. Identify the study area or service area for the proposed project as defined in the State Health Plan. If the identified service area is not defined in the State Health Plan, provide rationale for the area proposed.

2. In all cases, provides an analysis of the need for the project which, at a minimum, should address:

    a. Estimated population of the service area (current year and future five years). (Data provided by the Authority shall be used; in addition, the applicant may propose to use other data – in which event, the source of the data must be stated as well as the rationale for using it.)

    b. Calculation of need utilizing the methodology contained in the State Health Plan (Data provided by the Authority must be used; in addition, a need calculation may be stated based on the data used in response to question 2.a. of this Section E.)

    c. Other need methodologies may be used in the absence of a State Health Plan methodology or to supplement item b. (above).

    d. A map of the service area.

    e. A list of all of the existing providers of similar services and utilization rates for each of them.

1. What are the proposed hours and days of operation for the facility or health services?

4. What arrangements will be made for individuals requiring access to services during those hours that it is not operating?

SECTION F: POLICIES FOR PATIENT ADMISSION AND PROVISION OF UNCOMPENSATED CARE

1. Describe the facility's policies for patient admission as listed; include copies of policies or of proposed policies, if available.

a. Medical criteria.

b. Financial criteria.

c. Other criteria related to non-discriminatory access to services and placement.

2. Specifically describe policies for provision of uncompensated care as listed.

a. Note the projected value of 1) uncompensated care and 2) charity care, consistent with financial projections in Section O.

b. Describe admissions screening procedure for medically indigent patients.

c. If applicable, describe the facility's progress in meeting its Hill-Burton obligation or other charity care policies or requirements.

SECTION G: ANALYSIS OF ALTERNATIVES

1. Describe how this proposal is the most desirable alternative as compared to maintaining the status quo and providing the service in a less restrictive setting in terms of:

a. Financial feasibility.

b. Extent of construction, renovation, and related capital costs.

c. Capacity and utilization of existing providers of similar services in proposed service area (refer to Section E, item 2(e).

d. Cost containment.

e. Consumer input and participation.

f. Special considerations (if applicable):
   1. Energy efficiency.

   2. Improved access for medical and health professional training.

   3. Enhancement of biomedical and behavioral research designed to meet a national need.

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SECTION H: RELATIONSHIP TO EXISTING HEALTH CARE SYSTEM

1. Describe the project's relationship to the existing health care system in the service area with regard to accessibility and continuity of services.

2. List and describe the nature of all working relationships—formal arrangements that have been made to assure shared and support services. Attach copies of all agreements or proposed agreements.

Service/Facility	Nature of Agreement	Attached/ Will Be Developed

SECTION I: RELATIONSHIP TO THE APPLICANT'S LONG RANGE PLAN

1. Provide a copy of the facility's long range plan if not on file with the Authority.

2. Explain the relationship of this proposal to the facility's long-range plan.

SECTION J: RELATIONSHIP TO THE STATE HEALTH PLAN

1. Provide a documented analysis of the project's relationship to the State Health Plan. List each applicable objective in the State Health Plan chapter directly pertaining to the proposal and demonstrate the extent to which the project will meet each of those objectives, and the recommended actions.

SECTION K: ANALYSIS OF COMPETITIVE FACTORS

1. For each service being proposed or affected by this project, respond to the following.

   a. Describe the impact the proposal may have upon the utilization of similar services offered by existing providers in the service area.

   b. Describe the potential impact the proposal will have upon the cost of available services to consumers in the area; provide a comparison of charges for similar services in the proposed service area.

c. Describe the impact the proposal will have upon the quality of such health service(s) in the area.

SECTION L: RELATIONSHIP TO LICENSURE, CERTIFICATION, ACCREDITATION AND SAFETY STANDARDS

1. Describe the extent to which the proposal will be developed and implemented in accordance with state licensure, Medicare/Medicaid certification, accreditation, and fire and life safety code standards.

2. If the proposal serves to correct cited deficiencies in any of the aforementioned standards, explain. Attach copies of prior citations and/or statement of deficiencies and plan of correction.

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SECTION M: AVAILABILITY OF NEEDED RESOURCES

1. PROPOSED PLAN FOR FINANCING

Complete applicable items and describe source, type, amount, rate, etc. Attach documentation, letters of commitment, additional information as pertinent.

Type of Financing		Total Amount
____**Lease** (Check appropriate blanks) Land____ Building____ Equipment____		$_____
Fair Market Value $_____		
____ **Cash** Source: _____		$_____
_____		
____ **Conventional**		$_____
Principal	$_____	
Interest	$_____	
Term	$_____	
____ **Bonds**		$_____
Principal	$_____	
Interest	$_____	
Term	$_____	
Debt Service Reserve	$_____	
____ **Gifts**		$_____
____ **Grants**		$_____

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Type of Financing		Total Amount
____ Land Equity		$_____
____ Other Owner Equity		$_____
Notes	$_____	
Stock	$_____	
Other	$_____	
TOTAL FINANCING		$_____

2. Complete this schedule of staff required for the services affected by this project.

JOB CLASSIFICATIONS	CURRENT FTEs	PROPOSED FTEs

3. Present evidence of the availability of staff, including the medical staff, for the proposed project. Commitments or tentative commitments from prospective employees should be attached, if available.

4. If any facility-based personnel are to be provided through contractual arrangements, give the name of the secured or potential source(s) and the services to be provided. Attach a copy of a contract, draft contract, or letter of commitment from each source, if available.

SECTION N: POLICIES REGARDING STAFF EMPLOYMENT AND MEDICAL STAFF MEMBERSHIP

1. Provide copies of existing or proposed policies for training and employment of facility staff.

2. Describe the facility's policies and procedures for medical staff membership, including the policy concerning granting staff privileges to allopathic and osteopathic physicians.

3. Describe existing or proposed in-service training programs to the types of employees who are associated with the proposal.

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SECTION O: PRELIMINARY FINANCIAL FEASIBILITY

1. Provide historical and projected utilization for the facility using the following tables. Unless directed otherwise, provide data for the two past fiscal years, current and future fiscal years prior to the project's implementation, and the first two years after completions of the project.

   If this is a start-up project, provide data for the first four years of operations. On a separate sheet, set forth all the assumptions upon which the projections are based.

   INPATIENT DATA
   Provide the month and day for fiscal year ending _____

a. UTLIZATION STATISTICS	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient days:				
FY-1 19__				
FY-2 ____				
FY-3 ____				
FY-4 ____				
FY-5 ____				
FY-6 ____				
Inpatient charges:				
FY-1 ____				
FY-2 ____				
FY-3 ____				
FY-4 ____				
FY-5 ____				
FY-6 ____				

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b. AVERAGE LENGTH OF STAY	PAYOR CLASSIFICATION			
	MEDICARE	MEDICAID	OTHER	TOTAL
Inpatient days:				
FY-1 19__				
FY-2 ____				
FY-3 ____				
FY-4 ____				
FY-5 ____				
FY-6 ____				
Inpatient charges:				

c. BEDS AND OCCUPANCY	LICENSED BEDS	PERCENTAGE OCCUPANCY LICENSED	BEDS SET UP STAFFED	PERCENTAGE OCCUPANCY SET UP
Inpatient days:				
FY-1 19__				
FY-2 ____				
FY-3 ____				
FY-4 ____				
FY-5 ____				
FY-6 ____				

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Service	d. UTILIZATION STATISTICS				
	Value for Standard Units of Measure	**FY**	**FY**	**FY**	**FY**
1. Operating Room (General)	Surgery Minutes				
	Patients				
2. Operating Room (Ambulatory)	Surgery Minutes				
	Patients				
3. Operating Room (Open Heart)	Surgery Minutes				
	Patients				
4. Delivery and Labor Room	Births				
5. Outpatient a. Clinic	Patient Visits				
b. Emergency Room	Patient Visits				
c. Other____	Patients				
d. Psychiatric	Patients Visits				
2. Cardiac Catheterization	Procedures				
7. Radiological	Procedures				
8. CT Scan	Procedures				
9. MRI Scan	Procedures				
10. Kidney Transplant	Procedures				
11. Lithotripsy	Procedures				
12. Radiation Therapy	Procedures				
	Patients				
13. Home Health	Visits				
	Patients				

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2. CURRENT AND PROJECTED RATES

Please complete the following table as applicable to any changes or additions of service and/or beds.

	Actual for Current FY	As set by Prior Order	Projected with Proposal		
			1st Year	2nd Year	3rd Year
All beds Per diem rate					
Private	_____		_____	_____	_____
Semi Private	_____		_____	_____	_____
Hospitals Average charge per discharge	_____	_____	_____	_____	_____
Average charge per day	_____	_____	_____	_____	_____
All Charge for each proposed new services or for each service affected by the proposal.	_____ _____ _____		_____ _____ _____	_____ _____ _____	_____ _____ _____
Note: If the applicant is a hospital or if the proposal affects a hospital, as part of the CON order the Authority will set the rates for the proposal and will adjust previously set revenue limits pursuant to West Virginia CODE, 16-2D-1 et seq.,					

3. Submit statements of (1) revenues and expenses, 2) balance sheets, 3) statements of changes in fund balances, and 4) statements of cash flow for each of last two fiscal years. If audited financial statements have been prepared, submit them. If 10-K Reports are required to be submitted to the Securities Exchange Commission by either the applicant or a related entity, submit them for the preceding three (3) years.

4. Provide a preliminary financial feasibility study including, at a minimum, pro forma financial statements, to include 1) revenues and expenses, 2) balance sheets, 3) statements of changes in fund balances, and 4) statements of cash flow for each of last two fiscal years for the current fiscal year and future fiscal years prior to the project's implementation, and the first three years after the project's implementation. State all assumption used including projected payor mix, charges and/or revenues for each category of payor.

   APPLICANTS SHOULD CONSULT WITH THE CERTIFICATE OF NEED PROGRAM TO DETERMINE THE SCOPE OF THE PRO FORMAS TO BE SUBMITTED.

SECTION P: SPECIAL NEEDS AND CIRCUMSTANCES OF FACILITIES PROVIDING A SUBSTANTIAL PORTION OF SERVICES TO OUT-OF-STATE POPULATIONS

1. If the proposed service will provide a substantial portion of its services or resources to individuals not residing in the project's service area or in West Virginia, document that fact with pertinent information and data.

SECTION Q: COMMUNITY SUPPORT

1. If you wish, you may attach letters of support and endorsement from:

   - the service population at large
   - members of the medical community and provider organizations/institutions/services
   - consumer/civic organizations
   - community service providers

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The following affidavit must be completed by the chief executive officer identified in response of question 2 of Section A on page 1.

COUNTY OF
STATE OF _____, to wit:

Upon first being duly sworn, I hereby state that, to the best of my information, knowledge, and belief, the information provided in this application is true and correct. I further state that the applicant is in full compliance with the financial disclosure provisions of WV Code 16-5F-1 et seq. or W.Va Code 16-29B-1 et seq.

_____
(Signature)

_____
(Title)

Sworn to, stated, and subscribed before me on this _____ day of _____.

_____
Notary Public